



STATE TREASURER'S OPPORTUNITY ILLINOIS: HOSPITAL LOAN PROGRAM APPLICATION

APPLICATION TO PARTICIPATE IN THE TREASURER'S OPPORTUNITY ILLINOIS: HOSPITAL LOAN PROGRAM

This form is to be completed by an authorized representative of the organization seeking to borrow funds from a financial institution for a project that is eligible for support under the Opportunity Illinois: Hospital Loan Program sponsored by the Office of the Illinois State Treasurer Alexi Giannoulas. This form should be completed with the assistance of the financial institution that will be the lender. The information on this form will allow the Treasurer's Office to determine eligibility for participation in the program.

PLEASE TYPE ALL REQUESTED INFORMATION

Section 1

Applicant/Financial Institution Information

1.1 Describe Use Of Funds: _____

1.2 Applicant Information:

Applicant Name: _____

Address: _____

City, State, Zip: _____ County: _____

Fein #: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Contact Person: _____ Title: _____

1.3 Financial Institution:

Financial Institution Name: _____

Address: _____

City, State, Zip: _____ County: _____

Fein #: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Contact Person: _____ Title: _____

Section 2

Project/Loan Information

Please type the following information on separate sheets, as needed, in the following format. Use the section numbers provided.

2.1 Project Information:

- 2.1.1 Provide a detailed description of this organization and purpose of this project. Please attach a mission statement that identifies the hospital's commitment to serving the health care needs of the community and specify the date it was adopted.
- 2.1.2 Provide the most recent Community Benefits Plan and specify the date it was adopted. The plan must include the goals and objectives for providing community benefits including charity care and government sponsored indigent health care; identify populations and communities served by the hospital; and disclose health care needs that were considered in developing the plan.
- 2.1.3 Location of the project (street address _____ city _____, zip _____ and county _____).
- 2.1.4 Description of the benefit to the people of Illinois.
- 2.1.5 Detailed description of the proposed use of the funds requested.
- 2.1.6 Report Charity Care: Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services. Attach a copy of the current charity care policy and specify the date it was adopted.
- Charity Care \$ _____
- 2.1.7 Report of community benefits actually provided other than charity care.
- Language Assistant Services \$ _____
- Government Sponsored Indigent Health Care \$ _____
- Donations \$ _____
- Volunteer Services
- Employee Volunteer Services \$ _____
- Non-Employee Volunteer Services \$ _____

Education	\$ _____
Government-sponsored program services	\$ _____
Research	\$ _____
Subsidized health services	\$ _____
Bad debts	\$ _____
Other community benefits	\$ _____

*Please attach a schedule for any additional community benefits not detailed above.

- 2.1.8 Attach audited financial statements for the last two years.
- 2.1.9 For 501 (c) 3 non-profit organizations, please attach the non-profit certification letter from the Illinois Secretary of State tax-exempt letter from the IRS.
- 2.1.10 Borrower must provide a brief explanation why conventional loan financing is not adequate and why the Treasurer's linked deposit is the necessary incentive for the project to be implemented.

2.2 Project Information:

Term of loan (2 year initial deposit with a possible 3 year renewal): _____

Amount of deposit requested: \$ _____

Additional funding sources and amounts (list grants, other loans, etc.)

Source	Amount
_____	\$ _____
_____	\$ _____
Total cost of project (including this loan request and additional sources):	\$ _____

2.3 Funding Information:

2.3.1 Property Acquisition (attach a fully executed sales contract)	\$ _____
2.3.2 Construction/Leasehold Improvements: (Attach contractor's cost estimates)	\$ _____
2.3.3 Equipment/Machinery (attach quote from vendor)	\$ _____
Total	\$ _____

Section 3

Certifications & Acknowledgements

By signing below the applicant agrees and certifies as follows:

- The State Treasurer's Office may withdraw the deposit and the financial institution may accelerate repayment of the loan if the borrower fails to satisfy all of the requirements of the Opportunity Illinois: Hospital Loan Program.
- Neither the applicant, nor an immediate family member of the borrower, is a director, officer or employee of the financial institution or the State Treasurer's Office.
- The applicant understands that all information and documentation regarding the State Treasurer's Opportunity Illinois: Hospital Loan Program is public information. The State Treasurer's Office may release any information provided to it by the applicant and may also release any information regarding the approval or rejection of the application.
- The applicant understands that the State Treasurer's Office may reject any application for any reason at its sole discretion.
- The applicant will allow signage - provided by the Treasurer's Office - to be displayed at the project site listing contact information regarding this program.
- Borrower acknowledges that the Treasurer's Office may perform site visits at the project location for compliance purposes. Borrower also agrees to cooperate with the Treasurer's Office in carrying out the site visit.
- I certify, to the best of my knowledge, that the foregoing statements and the information I have provided are true and complete. I shall promptly notify the Illinois State Treasurer's Office of any changes in the information provided. I understand that a false or incomplete statement may result in the Treasurer's Office withdrawing the deposit and the financial institution accelerating the repayment of the loan without penalty and both entities seeking any other available relief. I also understand that an individual who provides a false statement may be subject to criminal prosecution under the Illinois Criminal Code (720 ILCS 5 et seq.).

Signature: _____ Title: _____

Print Name: _____ Date: _____

Please return this completed application and written Project/Loan Information (from Section 2) to:

Alexi Giannoulis
Illinois State Treasurer
Opportunity Illinois: Hospital Loan Program
100 West Randolph Street, Suite 15-600
Chicago, Illinois 60601
Phone: (312) 814-1244
Fax: (312) 814-3716
www.treasurer.il.gov